

www.mt.gov/dli/pha

APPLICATION FEE \$200.00 (NON-REFUNDABLE)

INSTRUCTIONS:

1. Make check or money order payable to the Montana Board of Pharmacy.
2. Review the Statutes and Administrative Rules of Montana on the internet at www.mt.gov/dli/pha
3. Include a schematic drawing (floor plan) of the pharmacy area.
4. If a pharmacy technician will be working in this facility, complete the Technician Utilization Plan application.
5. If this pharmacy will be dispensing controlled substances, complete the Dangerous Drug Act application.

APPLICATION: ☐ New Application ☐ Revision to Current License # _____
☐ Community ☐ Institutional ☐ Closed Door ☐ Class IV

Pharmacy Name: _____

Mailing Address: _____

Physical Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Fax: _____

Pharmacist-in-Charge: _____ MT License # _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Fax : _____

1. Please check the type of ownership or operation.
☐ Sole Proprietor ☐ Partnership ☐ Corporation ☐ Other _____

2. List the names and address of each owner and/or operator of the licensee.

3. List the name and license number of each registered pharmacist working in this pharmacy.

4. List regular business hours for the pharmacy.

5. Does this pharmacy intend to be accessible on-line? ☐ Yes ☐ No

6. Will you comply with all regulations of the Board of Pharmacy? ☐ Yes ☐ No

7. Do any of the applicant(s) and/or pharmacist-in-charge have criminal charges pending, or have they ever pled guilty or been convicted of a crime (including a plea of no contest or deferred prosecution) relating to, or committed during the course of their professional practice, involving violence, use or sale of drugs, fraud, deceit, or theft, whether or not an appeal is pending? You may omit: (1) traffic violations, for which you paid a fine of \$100.00 or less and (2) charges or convictions prior to the 16th birthday ☐ Yes ☐ No If yes, attach a detailed explanation

CERTIFICATE

State of _____
County of _____

Owner or Authorized Agent _____, being first duly sworn, upon oath deposes;

That he/she is the applicant named herein and does hereby represent that the statements given above in support of his application for license to operate a Certified Pharmacy are true and correct; that he/she specifically agrees to fully and promptly comply with the applicable federal laws, laws of the State of Montana and the rules and regulations of the Board of Pharmacy which governs this application, applicants business, and the sale of permitted drugs, pharmaceuticals, and commodities; and the applicant agrees to surrender any license issued hereunder upon demand for surrender by the Board of Pharmacy in the event of violation of laws and regulations.

Signature _____

Subscribed and sworn to before me this _____ day of _____, 2002.

(SEAL)

Notary _____
Residing at _____
Commission expires _____

CERTIFICATE

State of _____
County of _____

Pharmacist-in-Charge _____, being first duly sworn, upon oath deposes;

That he/she is the Pharmacist-in-Charge of the above named Pharmacy and will be the Pharmacist-in-Charge until the present license expires; that if the undersigned ceases to be Pharmacist-in-Charge prior to the expiration of the license, the undersigned will notify the Board of Pharmacy of such fact and failure to do so may be cause for suspension or revocation of Pharmacists license; that the undersigned agrees fully and promptly to comply with the applicable federal laws, laws of the State of Montana, and the rules and regulations of the Board of Pharmacy governing this application, applicants business, and the sale of permitted drugs, pharmaceuticals, and commodities.

Signature _____

Subscribed and sworn to before me this _____ day of _____, 2003.

(SEAL)

Notary _____
Residing at _____
Commission expires _____

MONTANA BOARD OF PHARMACY
301 S. Park Avenue, 4th Floor
P. O. Box 200513
Helena, Montana 59620-0513
(406) 841-2356 FAX (406) 841-2305
dlibsdpha@mt.gov
www.mt.gov/dli/pha

**APPLICATION FOR REGISTRATION TO DISPENSE UNDER
1973 AMENDMENTS TO THE MONTANA DANGEROUS DRUG ACT**

INSTRUCTIONS:

1. Make check or money order payable to the Montana Board of Pharmacy for \$35.
2. Review the Statutes and Administrative Rules of Montana on the internet at
www.mt.gov/dli/pha

Name: _____ Contact: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Fax Number: _____

DEA Registration Number: _____ Federal Tax I.D. Number: _____

If applying to dispense, please enter the Montana License Number for the pharmacy. _____

Signature _____ Date _____
(Signature of applicant or authorized individual)

Title _____
(if applicant is a corporation, institution or other entity)

*The average time for the office to process a correctly completed application is 5 days.